POLICY AND COMMUNICATIONS BULLETIN
THE CLINICAL CENTER

Medical Administrative Series

M94-10 (rev.) 26 September 2000

MANUAL TRANSMITTAL SHEET

SUBJECT: Restraint and Seclusion

1. Explanation of Material Transmitted: This bulletin transmits revisions to the policy of the Clinical Center regarding the use of restraints and seclusion in clinical care. The policy was reviewed by the Medical Executive Committee on 19 September 2000 and approved with changes reflecting current JCAHO and Health Care Financing Administration (HCFA) standards. The revised policy includes changes to the maximum time that may pass before 1) a written order must be obtained, and 2) a face-to-face evaluation is performed.

2. Material Superseded: MAS No. M94-10 (rev.), dated 5 May 1998

3. Filing Instructions: Nursing Section

   Remove: No. M94-10 (rev.), dated 5 May 1998

   Insert: No. M94-10 (rev.), dated 26 September 2000

DISTRIBUTION

Physicians, Dentists and Other Practitioners Participating in Patient Care

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SUBJECT: Restraint and Seclusion

PURPOSE

To define the appropriate and safe use of restraints and seclusion required to protect patients from harming themselves or others and to establish procedures for use of restraints and seclusion in compliance with JCAHO and other regulatory bodies.

DEFINITIONS

A **restraint** is any method of physically restricting a patient's freedom of movement, physical activity, or normal access to his or her body. In rare instances a staff member may use restraint and seclusion in response to an individual who asks to be restrained or secluded. The policy applies to this use of restraint and seclusion, even if their use is "voluntary."

Seclusion refers to the involuntary confinement of a patient alone in a room where the person is physically prevented from leaving.

POLICY

1. Restraints and seclusion will be implemented:

   a) whenever the physician, dentist, registered professional nurse, or other member of the credentialed medical staff assesses that restraint or seclusion is the least restrictive intervention that will provide safety to the patient, prevent injury to self or others, or prevent serious disruption of the therapeutic and clinical research environment.

   b) to reduce health and safety risks to patients while preserving the autonomy and rights of the patient to the extent possible, during medical, dental, diagnostic or surgical procedures. (This policy does not apply to adaptive or assistive devices that restrict movement or protect the whole or portion of a patient's body and are used to promote or maintain postural support. Protective devices may

include, but not limited to, bedrails, tabletop chairs, protective crib nets or bubbles, helmets, infant blanket wraps, and mechanisms such as orthopedic appliances, braces, wheelchairs or other devices used to posturally support the patient or assist him/her in obtaining and maintaining normative body function).

2. Restraints and/or seclusion may not be used as a mode or course of treatment (unless directed by an IRB clinical research protocol), as punishment, or for convenience. They must be used in a humane, safe, and effective manner without intent to harm or create undue discomfort to the patient.

3. Restraints and/or seclusion may only be used when:

   a) The patient's behavior poses either a threat of harm to self or to others or a serious disruption to the therapeutic environment, and
   b) Less restrictive or alternative approaches have been considered and, if clinically indicated, have been attempted and have found to be ineffective.

4. There will be NO PRN or standing orders for restraints or seclusion for any patient.

5. A patient will be placed in restraints in as dignified a manner as the situation permits, consistent with the safety of the patient and others

6. In certain clinical situations, a physician's order is not required to initiate the use of restraints. The "Restraint Use Pathway" is a clinical management tool to be used during the treatment of certain conditions, the administration of certain agents, or during the conduct of certain clinical procedures with the intent of reducing the risk for harm to patients. The use of the Restraint Use Pathway may be implemented for specific clinical situations such as but not limited to:
   - patients receiving therapies that may alter consciousness (e.g., the administration of IL2);
   - patients undergoing diagnostic procedures;
   - patients receiving interventions where there is a high potential for patient harm.

   The Restraint Use Pathway must be approved by the Medical Executive Committee and implemented by staff who have demonstrated clinical competence in proper use of restraints. The Deputy Director for Clinical Care is responsible for approving areas in the CC that may implement the Restraint Use Pathway.

   The restraint use pathway must include:
   - guidelines for assessing the patient
   - measurable application and release criteria to define patient selection for restraints
   - parameters for monitoring and reassessing patients for continued need of restraints
   - criteria for termination of restraints

7. Restraint events must be documented in the Occurrence Reporting System.

PROCEDURES
Implementation of Restraint and Seclusion Interventions

1. Restraint and seclusion are the most extreme interventions and require documented clinical justification that less restrictive interventions and/or techniques were deemed inadequate to provide the necessary protection.

2. The professional staff who implement orders for any type of restraint or seclusion must have successfully demonstrated competence in the proper use of restraints and seclusion.

3. **A physician, dentist, registered professional nurse or other member of the credentialed medical staff may institute restraints or seclusion in an emergency.** For all patients, a written order must be obtained within one hour of implementation of the restraint or seclusion.

4. The medical order must include:
   a. date and time order was obtained
   b. specific type of restraint to be used
   c. maximum duration of restraint or seclusion from the time the restraint and seclusion was initiated
   d. specific rationale for restraint and seclusion
   e. appropriate observation status
   f. special precautions, if any, to safeguard the patient
   g. the physician signature, or in the case of a verbal order, the names of the prescriber and the signature of the clinician receiving the order.

5. There will be NO PRN or standing orders for restraints or seclusion for any patient.

6. ***For non-behavioral health patients***, the licensed independent practitioner must perform a face to face evaluation of the patient within 8 hours of the initiation of restraints. Orders for non-behavioral health patients will not exceed 24 hours.

7. ***For behavioral health patients***, a physician, dentist or nurse practitioner must perform a face to face evaluation of the patient within one hour of implementation of the restraints. The licensed independent practitioner may write an order for restraint or seclusion for a period not to exceed 4 hours for adults, 2 hours for patient 9-17 years of age and 1 hour for patients less than 9 years of age. The initial order may permit a professional registered nurse, after reassessment, to continue the initial order for restraint or seclusion for periods of 4 hours for adults, 2 hours for patients age 9-17 years of age and 1 hour for patients under 9 year of age for a maximum of 24 hours from the time of the initial order.

8. The physician must write a progress note, within the initial 8-hour period for **non-*behavioral health*** patients and one hour for ***behavioral health*** patients. The note must include:
    a. Evaluation of the patient condition
    b. Plan of care for the patient
    c. Rationale for patient plan.

9. If a patient requires restraints or seclusion beyond 24 hours, a physician shall:
    a. Conduct a face-to-face evaluation of the patient to determine whether continued restraint or seclusion is appropriate; and
    b. Document the evaluation in the patient's medical record; and
    c. Comply with the requirements for time limited orders as outlined above.

10. Use of restraint may not be continued for more than 2 consecutive 24-hour periods (48 hours) without special consideration. To continue restraint or seclusion for greater than 48 hours:
    a. a physician shall document his/her clinical opinion that the patient continues to present a danger to self or others or would present a serious disruption to the therapeutic environment if released from restraint or seclusion; and
    b. Obtain and document authorization from the Institute Clinical Director, the Institute Clinical Director's physician designee or the Branch Chief, none of who may be the treating physician.
    c. The Institute Clinical Director, the Institute Clinical Director's physician designee or the Branch Chief will conduct a face to face evaluation of the patient who is restrained or secluded and may authorize continued restraint or seclusion for up to an additional 48 hours. - Restraint and seclusion beyond this timeframe requires face to face evaluation and authorization by the Clinical Director or designee.
    d. When a patient's treatment team recommends the continued use of restraints or seclusion (as described in #11 a and b) the team must:
        i. Review and document the appropriateness of continued use of restraint and/or seclusion; and
        ii. Establish and implement a plan to eliminate the need for continuous restraint and/or seclusion; and
        iii. Comply with the requirements for time limits as outlined in #7.

11. When a patient is placed in restraints or seclusion, an attempt will be made to notify the patient's family or guardian and provide education regarding the need for the restraint or seclusion and the plan of care, as appropriate.

12. The decision to remove restraints or to discontinue the use of seclusion is a collaborative one between physicians and nurses. A physician order to remove the restraint and seclusion, a note in the progress note with justification, and a medical plan of care are required in the medical record.

13. If an order for restraint or seclusion has been discontinued, a new order is required to reinstitute a restraint.

SPECIAL PATIENT POPULATIONS

A papoose board may be used as a restraint in a child under age 12 years old pursuant to a physician's written order. After one hour, the need to continue use of the papoose board as a restraint must be justified in the medical record and reordered by the physician for each subsequent one-hour period. Four point locked restraints shall never be applied to children under the age of 12 years.

PERFORMANCE IMPROVEMENT

Restraint and seclusion are high-risk interventions; therefore, ongoing assessments of these activities are crucial components of the Clinical Center clinical performance measurement program. The Clinical Center's Clinical Quality Committee, in collaboration with the Clinical Center Nursing department, coordinates performance measurement activities involving restraint and seclusion.

Attachment A
Restraint Use Pathway for Patients Undergoing Medical, Surgical, Diagnostic, and/or Dental Therapies or Procedures

This "Standards of Care" directs the use of restraints to reduce health and safety risks to patients and to promote or maintain necessary body functions while undergoing medical, surgical, diagnostic, or dental therapies. These therapies include, but are not limited to, airway maintenance, maintenance of life support, or care of patients receiving therapies that may alter consciousness. Standards of care for restraint use are based on patient needs. They use measurable criteria, promote the use of alternative methods to prevent harm, and direct frequency of assessment. Standards of care are implemented by professional registered nurses and are incorporated into plans of care designed to meet individual patient needs. Standards of care are used for the duration of the assessed patient need.

ASSESSMENT

The following factors must be assessed prior to initiation and during maintenance of restraint for patients undergoing medical, surgical, diagnostic, and/or dental therapies or procedures:

1. Real or potential behaviors that may interfere with the maintenance of normative bodily functions or behaviors determined to be a threat to physiologic stability or maintenance;
2. Factors underlying the behaviors identified above;
3. Effectiveness of less restrictive interventions designed to lessen risk to physiologic stability;
4. Need for ongoing use of restraint-every 30 minutes.

CRITERIA FOR APPLICATION OF RESTRAINTS

One or more of the following criteria will be used to justify the use of restraints for patients undergoing medical, surgical, diagnostic, and/or dental therapies or procedures:

1. depressed or unpredictable level of consciousness;
2. struggling that cannot be attributed to a controllable cause;
3. memory and or attention impairment;
4. disorganized speech and/or behavior;
5. physiologic compromise that could occur with position change or inadvertent removal of a life-supporting device;
6. inability to control movement leading to inadvertent removal of a life-supporting device.

INTERVENTIONS

1. Individualized interventions are designed to diminish or eradicate the effects of uncontrolled movement or positional change.
2. Interventions to meet physical needs will be performed at least q 15 minutes while the patient is restrained.
3. Individualized, less restrictive measures to prevent disruptive behaviors will be attempted and evaluated for efficacy.
4. Patients will be removed from restraints when criteria for discontinuation of restraints have been met.

CRITERIA FOR DISCONTINUATION OF RESTRAINTS:

One or more of the following criteria must be met prior to discontinuation of restraints for patients undergoing medical, surgical, diagnostic, and/or dental therapies or procedures:

1. stable or more predictable level of consciousness;
2. orientation to people, place, and time for an extended period of time;
3. organized mentation and/or speech;
4. organized behavior;
5. ability to maintain safe position.

DOCUMENTATION

Documentation in the medical record should include the following elements:

1. Assessment parameters;
2. Restraint application criteria;
3. Interventions, including alternatives and less restrictive measures;
4. Release criteria;
5. Discontinuation of restraint.